FAMILY CARE

... A HANDBOOK FOR SOCIAL WORKERS

FAMILY CARE PROGRAM

A HANDBOOK FOR SOCIAL WORKERS

REVISED FOR

THE DIVISION OF MENTAL HYGIENE
THE OHIO DEPARTMENT OF PUBLIC WELFARE

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FOREWORD

Because the use of Family Care for mental patients is relatively new in this country, in spite of its early beginnings, there is little literature available to help those who are concerned with developing a Family Care program.

The Ohio State Division of Mental Hygiene, in the process of developing such a program, felt the need of materials which would offer guidance and direction to institutional personnel. In response to this need, Mrs. Magnolia Culver, Chief Psychiatric Social Worker on the staff of this Division, has revised for use in the Ohio Family Care Program, two bulletins which she previously prepared and which were originally published by the Michigan State Hospital Commission in 1943-45. "Suggestions To Family Care Therapists" is designed for the use of those homemakers who are taking part in the program by caring for convalescent patients in their homes. "Family Care—A Handbook for Social Workers" seeks to describe the purpose of family care and to give guidance to social workers who are charged with successful supervision of the program.

The Ohio Division of Mental Hygiene acknowledges its debt to Mr. Charles F. Wagg, Executive Secretary, and to members of the Michigan State Hospital Commission for their courtesy in permitting us to publish a new edition of Mrs. Culver's two bulletins. We, in turn, publish the revised edition in the interest of better care for the mentally ill here and everywhere.

Mrs. Marjorie Watson, Chief
Mental Hygiene Information Service

June, 1947

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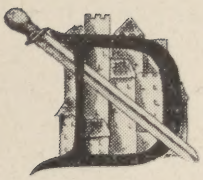
I

Family Care: Its Beginnings and Its Purpose



YMPHNA, Irish princess and patron saint of "lunatics," was the mother of family care. Out of her martyrdom grew the plan—first a custom, later an organized program—of placing patients in private homes for care.

Centuries ago, according to legend, Dymphna's conversion to Christianity so enraged her father that she and her spiritual advisor had to flee for their lives. They found temporary refuge in Gheel, Belgium, but were soon discovered by the king, who beheaded the priest and meted out the same treatment to Dymphna when she refused to recant. The story goes on to say that a number of "lunatics" who observed this cruelty were so frightened that they were "shocked" into sensibility. It was not long before the cry of "miracle" was raised, and Dymphna became the patron saint of "lunatics." As the legend spread, the mentally afflicted flocked to Gheel in large numbers, and because there was no mental hospital there, the people of Gheel cared for them in their own homes.

Belgium eventually recognized that what had evolved was a practical plan for the care of certain types of mental illness. In 1852 the program became organized and was made a definite part of the country's mental health planning. Scotland was next to see the merit in Family Care and community placements there date from 1857. France, Germany and Switzerland soon followed. The first state in the United States to see the value of such a program was Massachusetts. The Massachusetts program, which was established in 1885, has received new impetus in the last few years and has been extended and developed. In 1935 New York and Maryland joined the ranks, soon to be followed by California, Minnesota, Pennsylvania, Rhode Island, Utah, Illinois, Michigan, Virginia, and Ohio.

In the beginning the main reason for adopting a Family Care plan was economic. Undoubtedly it is a less expensive method of maintaining the mentally ill, since it reduces the need for hospital beds, thus slowing up capital expenditure. However, experience with a well organized program demonstrates in fact that the first value of Family Care is that of patient therapy. It is therapeutic because it provides a special type of family life relieved of the emotional stresses so often present in the patient's own home. Then, too, Family Care placements often successfully bridge the not inconsiderable gap between hospital and community living.

A Family Care program can also pay extremely valuable dividends in community mental health education. Through actual participation in the patient's rehabilitation, the community can learn that the hospital is not a place of permanent detention, but a treatment center where every effort is made to restore the patient to mental health. The people can acquire a greater understanding and consequently a healthier attitude toward mental illness and maladjustment. Any program that does not realize these possibilities is likely to result in a slow turnover of patients placed, as well as a lack of enthusiasm in the hospital, in the Family Care home, and in the community.

The following factors appear to be essential to the successful development of a Family Care program:

(1) One psychiatrist should be made responsible for the over-all supervision of the program. He should give it continuity and integration by stimulating close working relationships between all staff and ward personnel in the selection of the patients and in the total planning for their return to mental health.

(2) A social worker should be assigned to devote her whole time to the selection of homes and supervision of patients. With the psychiatrist, she interprets the purpose and philosophy of Family Care to the community. In selecting the home the social worker must evaluate the potentialities of the homemaker in terms of her therapeutic value to the patient.

(3) Sufficient homes reasonably near the hospital should be found.

Potential Family Care patients fall into two main groups: (1) those who are comfortable but chronically ill, and (2) those who need convalescent care before resuming their place in the community. Both should have received the maximum benefits of all of the curative facilities of the hospital but may not have adjusted sufficiently to enable them to return either to their own homes or to their own individual places in the community. While hospital routine with its complete freedom from responsibility is greatly therapeutic during acute illness, it may actually become a destructive influence if the patient remains beyond a point of optimum benefit. The Family Care home which provides the necessary understanding and security is the obvious answer to this dilemma for both hospital and patient. It is to be remembered, however, that all patients, regardless of type, must be placed with therapeutic insight and intent. This means careful individual planning as a primary necessity, with emphasis on helping the patient to take the next step in his adjustment as he is ready for it.

Many of those patients in the first group mentioned have been in the hospital for years. Although mentally ill, they are harmless and can get along quite well with the special supervision provided by the social worker under the guidance of the psychi-

atrist. In this group, in addition to those with the common functional disorders, are patients whose illness is caused by cerebral arteriosclerosis or senility. Some amazingly good results have come from Family Care for these patients.

Convalescent patients of the second type are placed in Family Care because life in a selected home under supervision provides the stabilizing influence necessary to a satisfactory and lasting adjustment. It is a transition period during which the social worker not only has an opportunity to carry on intensive case work with the individual patient, but also has a further opportunity to improve the relationship between the patient and members of his own household. The usefulness of this procedure is frequently substantiated by patients who freely acknowledge the help they have received. Family Care has given them an interval sufficient to regain their equilibrium and relearn the ways of everyday living. Experience has shown that, for the patient, Family Care can blend improvement into full recovery.

Individual planning is essential to the success of Family Care. It also demands cooperative effort and all the skills of psychiatrist and social worker alike. In the early stages of its development this new and unfamiliar program may bring with it disappointment, frustration and doubt. But the first successful placement and the observing of its therapeutic good will be an effective antidote to discouragement, and it will not be long before infectious enthusiasm and real understanding follow.

II

Finding the Family Care Home

Although the placing of patients in Family Care homes is not a new venture, even in the United States, its development has been so sporadic that few people are aware of its existence. For this reason considerable preparation is essential before such a program can be initiated. Much interpretation must be made, both to individuals and to groups, before a community will accept the program and before people will consider taking patients into their homes.

Selection of the right home is of vital importance. Since the hospital staff depends on the social worker's evaluation of the home in considering it for a particular patient, she assumes a responsibility in its behalf. Her success in this venture, as in other areas of the program, is dependent not only on her training and experience, but also on her attitude toward mental illness and her understanding of Family Care as a treatment facility.

Developing Community Interest

Securing suitable homes is not only time-consuming but also may be very discouraging. However, a systematic plan of action is a time-saving device and enables the worker to see what is being accomplished.

The hospital area should first be surveyed for a desirable community or district within a workable radius of the hospital. Some institutions are situated in crowded areas and the Family Care homes must of necessity be located at some distance. Regardless of where homes are found, close supervision is essential.

The community or district should then be evaluated on the basis of its employment and educational opportunities, recreational resources, housing conditions and transportation facilities during all seasons. Once this has been done, a series of interviews should be planned with key people such as physicians, public health nurses, ministers, priests, county welfare and county agricultural agents, to acquaint them with the program and ask them to suggest people who might be interested in taking patients. Local social agencies, such as Children's Aid societies, family service agencies, and county welfare boards should also be familiarized

with the program. These groups are helpful not only in interpreting family care to others but are also a source of Family Care homes. Hospital employees often prove helpful in suggesting the names of families who might wish to take patients. Former hospital employees are sometimes themselves interested in taking patients. These contacts, plus the publicity that has already been given the program, are the first steps in securing Family Care homes.

To interpret the program further, both the psychiatrist and the social worker should take advantage of opportunities to talk before service clubs, parent-teacher associations, Grange meetings, and ladies' aid societies. It is important to note here that their interpretation of Family Care should focus attention on *the patient as a potential functioning member of society* rather than on his *symptoms* alone.

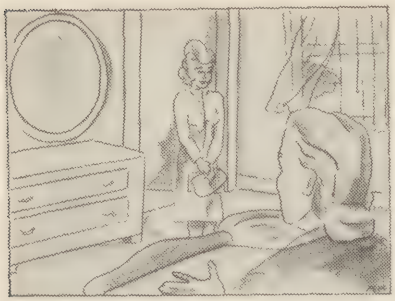
The community's knowledge and understanding of Family Care is increased through observation of and participation in patient rehabilitation. It grows in understanding, not only of the individual patient but of the whole problem of the mentally ill. In the process of community education, the successful Family Care therapist is not only one of the best interpreters of the program but the best resource in home-finding.

Selecting the Family Care Therapist

In the first interview with the prospective Family Care therapist, the social worker should explain the purpose of placing patients in private homes. She should stress the fact that, as a participant in the adventure in rehabilitation, the Family Care therapist can be one of the contributing factors in the patient's ultimate adjustment. It should be emphasized that the patients placed are harmless, having been carefully selected before placement. The Family Care therapist should also be told that the hospital continues to be responsible for the patients and that the social worker will make regular visits to the home to give help in understanding and handling the patients. The psychiatrist will make less frequent visits, but either of them, or some other member of the hospital staff, will always be available in an emergency.

During this and subsequent interviews, the prospective Family Care therapist has an opportunity to become acquainted with the responsibilities and satisfactions of the job. By the close of the interviews she should be able to indicate how she feels about participating in the program. At the same time the social worker should be able to evaluate the prospective family care therapist's potentialities on the basis of her manner and response. These potentialities are appraised by the social worker in terms of their therapeutic value to the patient. If the Family Care therapist's basic motivations are her own emotional needs, she cannot help the patient. *The Family Care therapist should be a well-adjusted, flexible, warm, interested person who, with the help that is given*

by the psychiatrist and the social worker, can develop skill in dealing with minor behavior problems.



In general, successful Family Care has been found to develop around the personality of the Family Care therapist. However, the patient's adjustment and subsequent improvement is directly related to the interest, help and understanding he receives from *all* members of the family with whom he is placed. In some homes it is the man whose influence is the most therapeutic. In another it will be the Family Care therapist's, and in some instances the children will have the most meaning for the patient. But in every case the recognition of the therapeutic potentialities of all personalities is an important factor in the evaluation of the home.

Although both the Family Care therapist and her family should be tolerant and have a sincere interest in the patient, the responsibility for the success of the placement depends largely on the Family Care therapist herself. Not only must she see that the patients receive the necessary physical care, but it is she who keeps the family and patient living in harmony without jeopardizing the happiness of either. To maintain this balance requires a well-adjusted, sympathetic person who accepts Family Care as a satisfying challenge to her ability and welcomes the opportunity to earn in this way.

It is important for the social worker and the hospital staff to recognize that a home operated by an interested person, willing and able to benefit by interpretation and guidance, is vastly different from the traditional boarding home. A successful Family Care therapist does more than provide a place to live. She performs a vital service in the process of helping patients to find their place in the community.

Selecting adequate homes is a difficult job. Unfortunately, some of those homemakers who appear to be most anxious to participate in such a program are unsuitable. No matter how difficult homes are to find, the worker should avoid accepting inadequate ones in her eagerness to get the program under way and "make a showing." By taking unsuitable homes she puts a premium on her time from the standpoint of supervision, and in so doing she "short circuits" the patient. Her carefulness and skill in refusing unsuitable homes is of great importance. On this will depend, to a large degree, the acceptance and popularity of the program in the community, as well as the continued good will of many would-be Family Care therapists. It is the social

worker's responsibility to handle the situation with consideration, tact and dignity, so that it will be a positive experience for all concerned.

Some of the reasons for rejecting homes are:

(1) The presence of a negative attitude about mental illness.
(2) The danger of exploitation of patients.
(3) Excessive emotional needs on the part of the Family Care therapist.
(4) Interest prompted only by a monetary need.
(5) Poor health of the Family Care therapist, or other serious illness in the home, such as tuberculosis.
(6) Lack of acceptance of the plan by other members of the family.
(7) Minor children in the home. This is not a definite deterrent to placement, but should be taken into careful consideration before a placement is made.
(8) Home unsuitable from a physical standpoint.

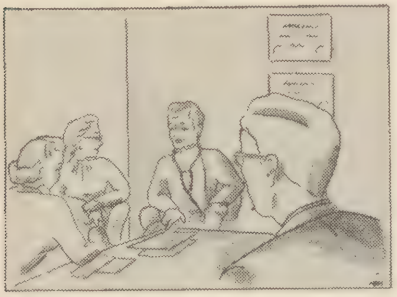
Although the personality of the Family Care therapist and intelligent acceptance of the patient into her family are more important than the home's physical surroundings, the latter factor cannot be ignored. As a guide in considering the physical characteristics of the Family Care home, the following suggestions are offered:

(1) The home should meet certain minimum requirements as to sanitation, heat, ventilation, lighting and fire protection. Where no fire escapes exist, patients should be placed no higher than the second floor. The local or county health and fire departments should be consulted to determine whether the home conforms to basic sanitary and fire regulations. Zoning authorities should also be consulted to determine whether the presence of Family Care patients in the home will conflict with established zoning regulations. Local authorities should be consulted to determine whether a boarding home license is required.
(2) There should be comfortable, homelike quarters for the patients where they can have a certain amount of privacy.
(3) There must be a bed for each patient and adequate space for clothing.
(4) Not more than two patients should share the same room unless the room is unusually large and airy.
(5) Facilities for taking at least one full, warm bath a week are necessary.
(6) Three well-balanced meals a day must be provided.
(7) The linen supply should be sufficient for one change weekly and the bed covering should be suitable to the weather.
(8) It is preferable that the home have a telephone. If there is no telephone, it is imperative that arrangements be made for contacting the hospital in an emergency.

III

Placing the Family Care Patient

Selecting the Patient



Close cooperation between all members of the hospital staff is highly important to a successful Family Care program. In the selecting of the patient there is no adequate substitute for joint conferences of medical staff, social workers, occupational and recreational therapists, and any others who know the patient well. The conference must consider each patient individually from the standpoint of his physical, psychiatric, intellectual and social status. This information is obviously necessary before the social worker, with the advice of the Family Care psychiatrist, can choose the home which will most adequately meet the needs of the patient to be placed.

The actual selection of the patients is such a highly individualized procedure that no "rule of thumb" can be sufficiently inclusive. However, there are a few behavior types to be avoided in placement:

(1) Patients who are suicidal or disturbed.
(2) Patients whose behavior is extremely bizarre and erratic.
(3) Those whose sexual impulses or behavior might lead them into difficulties or be of concern to the community.
(4) Those having frequent and severe convulsions.
(5) Those who are quarrelsome and overly supicious.
(6) Those in need of specialized nursing care or medical attention.
(7) Those who are bizarre in their dress.

When a hospital is beginning a program, only mildly ill mental patients should be placed. Family Care therapists are inexperienced and untrained in the handling of the mentally ill and the community still has many reservations about such a program. The utmost care should be taken to place only those patients who are likely to cause a minimum of embarrassment to the Family Care therapist and the community. A few bad placements in the beginning may seriously retard the growth of the program. After local residents have become accustomed to having mental patients for next door neighbors and the community becomes more receptive, patients requiring more skillful handling can be placed.

Experience has demonstrated the value of Family Care for the following general types of mental patients:

(1) Patients who have recovered from their acute symptoms, but are not well enough for trial visit.

(2) Patients who are tractable and adjusted to hospital living but for whom there is no prospect of trial visit because their homes are unsuitable or no longer exist.

(3) Patients who are potential recipients of Aid for the Aged.

The final decision regarding patient selection should be made after consideration by the supervising psychiatrist and the social worker of the following information from hospital records, conversations with the patient and his family, the ward physician, and other hospital personnel:

(1) The patient's social and psychiatric history.

(2) His personality liabilities and assets.

(3) The predisposing and precipitating factors in his illness.

(4) The specific treatment plan at the hospital.

(5) The patient's hospital adjustment.

(6) His present mental status.

(7) His present physical condition.

(8) His attitude toward his illness and hospitalization.

(9) His attitude toward his family, work and community.

(10) His attitude toward Family Care.

If on the basis of this information the patient is considered a likely candidate for Family Care, the plan should be discussed with him and recommendations made as to the type of home that will most adequately meet his needs. The social worker as a participant in the planning will know the case well and be in a position to search for a home that at least approximates the psychiatrist's "prescription" for the patient.

Gaining the Patient's Cooperation

Because Family Care is a new idea to the patient, he should be fully acquainted with its purpose and should be a participant in the planning. The advantages and disadvantages of Family Care should be carefully explained to him, and he should have sufficient time to consider the plan. A patient sometimes feels that if he is well enough to leave the hospital he is well enough to go to his own home. It should be emphasized that Family Care is a stepping stone toward that end.

Occasionally a negative attitude toward Family Care is encountered in a patient who might be otherwise responsive. A trial period should still be arranged if, in the opinion of the hospital staff, the patient would benefit by this type of therapy. The patient should be told that if the home does not measure up to his expectations, or if he is unhappy there after he has given it a fair trial, another home will be found or he will be allowed to return to the hospital. It is important to discuss plans with the patient in order that he will feel that he is participating in them. As a result he will cooperate more fully and there will be a greater possibility of successful placement. The patient should be assured that if he wishes he can return to the hospital for special entertainments or visits with old friends. Such contacts not only make the transition period easier for the patient of long hospitalization, but also help to interest other patients as well as the hospital personnel in the benefits to be derived from Family Care.

Working with The Patient's Family

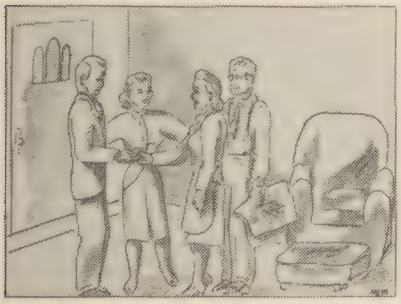
The patient's relatives may offer resistance to Family Care placement for reasons that seem sufficient to them. The most common objection of relatives is their feeling that if the patient is well enough to leave the hospital he is well enough to be at home. Another concern felt by relatives is that the Family Care therapist will not provide adequate care and interest. Occasionally they express fear that the patient might interfere with their life in some way or might be dangerous to the community.

These objections may be offered partly out of a defensive attitude. They may stem from a feeling of guilt aroused by the thought that a stranger is willing to undertake a responsibility which the relatives themselves are deemed unsuitable to fulfill. When these problems are dealt with through adequate case work understanding, it is possible to help family members understand their own feelings and participate in the plan. The elements of convalescence should be explained. It should be pointed out that a readjustment of attitudes on the part of all concerned will eventually make it possible for the patient to live again in his own family or to live independently in the community. In the meantime, relatives should be encouraged to accept Family Care as another step in the patient's treatment.

IV

Supervising the Family Care Program

Close supervision of patients placed in Family Care homes is unquestionably of the utmost importance. It is in this area that the social worker has opportunity of exercising her skills to the fullest. She will, of course, receive help from the supervising psychiatrist. Moreover, his assistance must be continuous throughout placement, since the success of Family Care depends to a great extent on the joint efforts of the psychiatrist and the social worker.



Since much of the actual treatment of the patient is done by the Family Care therapist, her relationship with the social worker must be one of mutual respect, understanding and confidence. As a first step in this direction, and before the first placement is made, there should be agreement between the hospital and the Family Care therapist on such matters as responsibility for supervision, provision for medical care and clothing, etc. It should be pointed out that, in selecting patients for placement, the hospital staff has chosen those who they feel will benefit most by association with the Family Care therapist and members of her family. The Family Care therapist, as a participant in the program, shares the hospital's responsibility in assisting these patients to make as good an adjustment to community living as possible.

At first it will be difficult for the Family Care therapist to give the patient full acceptance. Therefore, in order that she will feel more secure in her new venture, she should be given as much information about the patient's personality as is necessary to help her understand and meet his needs. The social worker should acquaint the Family Care therapist with any peculiarities which the patient might manifest, should help her acquire an understanding of his mental make-up, and should inform her regarding any special problems.

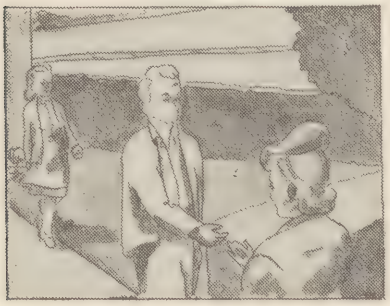
For example, it should be explained that situations arising in the care of the mentally ill are as varied as the patients themselves, so that no one type of behavior can be anticipated. Some patients need to be cajoled into doing simple things around the house, while others have to be watched to keep them from working beyond their strength. Some like a great deal of attention;

others like to be left alone. They may be changeable in mood —at times depressed, somewhat irritable, or overactive. However, if they are treated with the same kindness and consideration that is due anyone who is not feeling well, they will usually respond.

It is important that peculiarities in the patient's behavior should not be laughed at or discussed with others in the patient's presence. If patients are treated at all times as nearly like normal individuals as possible, the association will be more enjoyable for the Family Care Therapist and much more beneficial to the patient.

Patients are not placed in Family Care unless they are well enough to enjoy greater freedom than was feasible in the routine living of the hospital. For this reason the Family Care therapist should encourage them to participate, as much as possible, in the normal activities of the home. Sharing in these activities not only imparts a greater feeling of belonging but helps to show the patient the comforts and satisfactions which may be found in a world of reality.

It should be made clear to the Family Care therapist that the social worker's regular visits to her home will be of mutual benefit to both. In these visits the social worker will help the Family Care therapist to understand and meet the needs of individual patients and encourage them to take the next step in their adjustment as they are ready for it. It should also be explained to the Family Care therapist that the social worker will want to talk with the patient himself, in order to help him with his problems and assure him that the hospital staff is interested in his progress. The Family Care therapist should be encouraged to express her feelings, negative and positive, that stem from this new experience. The patient should be given the same opportunity to express his feelings. As a result, misunderstanding may be avoided and suggestions may be made for the future handling of similar situations. In other words, the social worker should help the Family Care therapist to gain something of value from each patient, to recognize and utilize each sign of improvement and, most important of all, to accept the patient's limitations and relapses.



The frequency of the social worker's visits should be determined by the individual case, the patient's condition, the experiences and skill of the Family Care therapist, and the recency of the placement. Although the Family Care therapist should be assured that the social worker, or some other member of the hospital

staff, will always be available in an emergency, she should be encouraged to exercise resourcefulness and ingenuity in dealing with problems as they arise. Overanxious and overmeticulous supervision is almost certain to result in discontinued homes or overly dependent Family Care therapists.

The Family Care therapist will need help, not only in accepting the patient but in accepting his friends and relatives. Their visits may frequently expose her to modes of behavior and attitudes different from her own ways of feeling and living. Again, supervision will help her to understand relatives' attitudes toward the patient and to appreciate why they behave as they do. Who should visit the patient and how frequent the visits should be is a matter to be determined by the social worker in consultation with the supervising psychiatrist.

One of the most helpful ways to increase the Family Care therapist's understanding of her job is to have occasional group meetings at which time she can go through the hospital and meet members of the hospital staff and other Family Care therapists. Such meetings not only help create a greater feeling of participation in the hospital's treatment program but also afford her an excellent opportunity for constructive discussion of mutual problems.

At the beginning of the program it is best to place patients at a tempo which will afford the Family Care therapist an opportunity to know each patient. Patients of similar interests and cultural levels should be placed together when possible. In order that the patient will feel less uprooted and will adjust more readily to his new environment, it is sometimes wise to place in the same home those who were friends in the hospital and lived together on the same ward.

A patient should be placed as soon as possible after approval by the hospital staff, because deferred placement reduces the patient's interest, increases his anxiety, and leads to doubt as to whether he really wishes to go. If the patient is dissatisfied in the home and if the dissatisfaction is not merely one of his habitual mental symptoms, the social worker should arrange for another placement. Some of the reasons why a change in placement may be necessary are listed below:

(1) When a patient is placed, it may be found that although his needs and the needs of the home were carefully considered, the placement did not meet them.

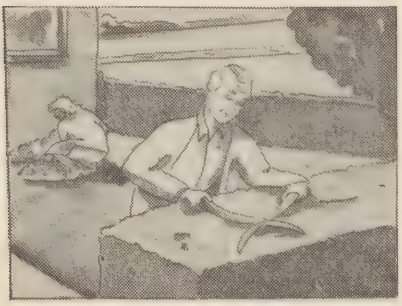
(2) If, despite careful selection, the patient demonstrates his inability to adjust in the comparative freedom of the Family Care home, it is important to remove him quickly to avoid creating an unfavorable impression of Family Care in the community.

(3) Occasionally a patient outgrows his first placement. His mental condition may improve so that he can adjust to a type of home even more nearly like his own. For

example, the medical staff might consider it wise to place an urban patient in a rural environment as a first step in convalescence. As improvement occurs a move to a city home may be justified as a final step in rehabilitation.

Since the primary aim of Family Care is to help the patient make as satisfactory an adjustment to a normal way of living as possible, his appearance must in no way set him apart. Upon leaving the hospital he should be provided with sufficient clothing so that he may be clean and dressed appropriately for the season and environment. Being suitably dressed is as therapeutic to the mentally ill person as it is to any one of us. Even the patient who has been in the hospital for a number of years develops an amazing interest in his appearance. It is also important to allow patients to take their little treasures with them. The possession of small articles, such as watches, and especially wedding rings for women, helps surprisingly in rebuilding the patient's dignity and self-confidence.

Experience has shown that an allowance given patients who are without funds contributes toward their well-being and good adjustment. A minimum of twenty-five cents a week should be allowed each patient and in special cases, at the discretion of the hospital superintendent, this amount may be increased. However, generally speaking, it may be more therapeutic to encourage the patient to earn additional spending money rather than to receive an increased allowance either from relatives or the Family Care fund. Such work as odd jobs on a farm, shovelling snow, cutting and raking lawns, small cleaning jobs in the neighborhood, needlework, etc., are remunerative in a small way and contribute to the patient's feeling of accomplishment.



As long as the patient is in the Family Care home it is the social worker's responsibility to continue to encourage, through interpretation, the relationship between the patient and his own family. In other words, the family should be helped to develop a healthier attitude toward mental illness and a broader understanding of the patient's liabilities and assets. Close cooperation between medical staff and the social worker in working with the patient's famliy during the period of hospitalization immeasurably simplifies the transition period.

The psychiatrist responsible for the over-all supervision of the Family Care program will visit all homes periodically to check on the patients' health and progress. He will appraise the

adequacy of the homes, in order to give the Family Care therapists and the social worker more constructive assistance in meeting the needs of individual patients. As a result, he will also be in a better position to interpret the many ramifications of the program to the entire staff. It is likely, in the early stages of development, that the psychiatrist as well as the social worker will become enthusiastic over the program only after they have seen it in operation in all areas of activity.

With the practical knowledge that is gained and the skill that is developed through actual participation, all concerned with the development of the program will become more adept in handling their particular problems and will have a greater appreciation of the benefits to be derived from Family Care. The difficulties and obstacles encountered in home finding and resulting from unsuccessful placements become less discouraging as the program grows. The hard preparatory work reaps sizable dividends in increased happiness for the patients and in a feeling of satisfaction to those whose activities have been devoted to the development of the program.

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